

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
W0000	<p>This visit was for the investigation of Complaint #IN00111572.</p> <p>COMPLAINT #IN00111572: SUBSTANTIATED, Federal and state deficiencies related to the allegation are cited at W122 and W149.</p> <p>Dates of Survey: July 9 and 10, 2012.</p> <p>Facility number: 001018 Provider number: 15G504 AIM number: 100239810</p> <p>Surveyor: Tim Shebel, Medical Surveyor III</p> <p>The following federal deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 7/16/12 by Ruth Shackelford, Medical Surveyor III.</p>		W0000				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met.</p> <p>Based on record review, observation, and interview, the Condition of Participation of Client Protections is not met as the facility failed to protect 1 of 2 sampled clients (client B), with known elopement risks, from eloping from the facility in regards to 1 of 1 reviewed elopement incidents.</p> <p>Findings include:</p> <p>Please refer to W149 as the facility neglected to implement its abuse/neglect policy to protect 1 of 2 sampled clients (client B), with elopement risks, from eloping from the facility in regard to 1 of 1 reviewed elopement incident.</p> <p>This federal tag relates to complaint #IN00111572. 9-3-2(a)</p>			W0122	<p>Elopement is addressed in Client B's BSP. There is a Protocol in place and all staff had been trained in both. All preventative measures were in place and working at the time of this incident. Staff #7 received a write up and was retrained.</p> <p>Responsible person: Traci Hardesty, Program Coord. A new louder alarm was installed on the outside of egress, which has a code that can only be turned off by staff. Responsible person: Traci Hardesty, Program Coord. A motion sensor was installed on the stairs of egress. Responsible person: Traci Hardesty, Program Coord & Maintenance. All staff were retrained on the BSP & Protocol. Responsible person: Traci Hardesty, Program Coord. A video camera to be installed in hallway of where Client B's bedroom is located and the monitor will be carried by the awake staff. Responsible person: Traci Hardesty, Program Coord. & Maintenance. All staff will be retrained on the camera system following installation. Responsible person: Traci Hardesty, Program Coord. To ensure compliance and Client B's safety, awake staff will do a bed check every half and check that the bedroom alarm is turned to the on position. Responsible person:</p>		07/27/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012

FORM APPROVED

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
					Betty Moody, Group Home Manager & Traci Hardesty, Program Coord.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client.</p> <p>Based on record review, observation, and interview, the facility neglected to implement its abuse/neglect policy to protect 1 of 2 sampled clients (client B), with known elopement risks, from eloping from the facility in regard to 1 of 1 reviewed elopement incident.</p> <p>Findings include:</p> <p>The facility's records were reviewed on 7/9/12 at 1:28 P.M.. A review of incident reports from 1/1/12 to 7/9/12 indicated the following elopement incident involving client B:</p> <p>"Name: [client B], Date: 07/01/2012, Narrative Details: [Client B] went to bed at his usual time of 10pm. At 11:30pm, he got up to use the bathroom. Staff (direct care staff #7) felt that he (client B) was acting funny that evening, really watching staff's movements and looking at the windows a lot. So at 11:30pm, she (direct care staff #7) had [client B] come upstairs to sleep. He went to sleep shortly thereafter and got up to use the bathroom again at 1:30 am. At 3:15am, 2 police officers knocked on the door of the group home and had [client B] with them. He</p>			W0149	<p>Elopement is addressed in Client B's BSP. There is a Protocol in place and all staff had been trained in both. All preventative measures were in place and working at the time of this incident. Staff #7 received a write up and was retrained. Responsible person: Traci Hardesty, Program Coord. A new louder alarm was installed on the outside of egress, which has a code that can only be turned off by staff. Responsible person: Traci Hardesty, Program Coord. A motion sensor was installed on the stairs of egress. Responsible person: Traci Hardesty, Program Coord & Maintenance. All staff were retrained on the BSP & Protocol. Responsible person: Traci Hardesty, Program Coord. A video camera to be installed in hallway of where Client B's bedroom is located and the monitor will be carried by the awake staff. Responsible person: Traci Hardesty, Program Coord. & Maintenance. All staff will be retrained on the camera system following installation. Responsible person: Traci Hardesty, Program Coord. To ensure compliance and Client B's safety, awake staff will do a bed check every half and check that the bedroom alarm is turned to the on</p>		08/03/2012

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>(client B) had gotten out the window and was in the candy aisle at [local drugstore] eating candy. [Client B] came home and went back to bed in his bedroom. He had no injuries and did not appear to suffer any ill effects from the incident. Plan to Resolve: [Client B] has had a few incidents of elopement in the past and there are protocols put in place to prevent more incidents. During waking hours, [client B] carries a cell phone with a GPS (Global Positioning Satellite) locator system. There are alarms on all exits to the group home. When he is in bed, staff set an alarm on the outside of his door so that when he exits his room, the alarm will sound and notify staff of his movements. In this case, the protocols were not followed. Had [client B] been left in his bedroom to sleep throughout the night, he would not have gotten out of the house unnoticed. When the protocols that have been put in place are followed, [client B] cannot leave the house without an alarm sounding. The staff who was working will be re-trained on [client B's] behavior plan which includes the protocols to prevent elopement. She (direct care staff #7) will receive a disciplinary action as well."</p> <p>Client B was observed at the group home on 7/9/12 from 3:35 P.M. until 4:30 P.M.. As client B walked throughout the facility</p>				<p>position. Responsible person: Betty Moody, Group Home Manager & Traci Hardesty, Program Coord.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE			
	<p>direct care staff #2 was observed to be within eye sight of the client. A door alarm was noted to sound whenever client B entered or exited his bedroom.</p> <p>Direct care staff #2 was interviewed on 7/9/12 at 4:33 P.M.. Direct care staff #2 stated staff were to be "within eye sight of [client B] at all times when he is awake."</p> <p>Direct care staff #1 was interviewed on 7/9/12 at 4:39 P.M.. Direct care staff #1 indicated she works the overnight shift as well as the afternoon shift. Direct care staff #1 stated, "We (over night shift staff) have to have [client B] sleep in his own bedroom because it has an alarm on the door. The night he eloped, staff (direct care staff #7) had [client B] sleep in a bedroom off of the living room. That room doesn't have alarms on the doors or windows."</p> <p>Client B was observed at the group home on 7/10/12 from 5:30 A.M. until 7:30 A.M.. Upon entrance to the facility, client B was in his bedroom with the door closed. Direct care staff #3 visually checked on the client at 6:00 A.M. and woke the client at 7:00 A.M.. After the client rose for the day, direct care staff #3 was observed to be within eye sight of the client.</p>						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	<p>Direct care staff #3 was interviewed on 7/10/12 at 7:33 A.M.. Direct care staff #3 stated he was to assure client B was sleeping in his own room with the door alarm and to check on the client "every hour." Direct care staff #3 indicated after client B was up for the day, direct care staff were to be within eye sight of the client.</p> <p>Client B's records were reviewed on 7/10/12 at 8:45 A.M.. A review of the client's 9/29/11 Behavior Support Plan indicated he had a targeted behavior of elopement. The plan indicated client B had a door alarm on his bedroom door which would sound when and if the client would exit his room during sleeping hours.</p> <p>QMRP (Qualified Mental Retardation Professional) #1 was interviewed on 7/10/12 at 9:07 A.M.. QMRP #1 stated, "He (client B) had not eloped from the group home since around November 2010. It (7/1/12 elopement) happened because staff (direct care staff #7) did not follow [client B's] behavior plan and the protocol we have in place. QMRP #1 further stated direct care staff #7 did not notice client B had eloped because "she (direct care staff #7) was cleaning in the kitchen and did not hear him (client B) leave. All staff have since been retrained</p>						

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G504		X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING		X3) DATE SURVEY COMPLETED 07/10/2012	
NAME OF PROVIDER OR SUPPLIER IN-PACT INC				STREET ADDRESS, CITY, STATE, ZIP CODE 211 W 76TH AVE MERRILLVILLE, IN 46410			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE		
	<p>on [client B's] behavior plan and protocol." QMRP #1 further stated direct care staff #7 "was neglectful" in not assuring client B slept in his own room with the door alarm.</p> <p>The facility's records were reviewed on 7/10/12 at 8:54 A.M.. A review of the facility's "Policy On Reporting And Investigating Incidents And Allegations Of Abuse And Neglect" (not dated) indicated, in part, the following: "Abuse and neglect or any mistreatment of any consumer who resides in an InPact residential setting is strictly prohibited... ."</p> <p>This federal tag relates to complaint #IN00111572. 9-3-2(a)</p>						